STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING _____ B. WING _____	C 08/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	**377 WESTRIDGE BLVD GREENWOOD, IN 46142**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00153914 and IN00154236. Complaint IN00153914 - Unsubstantiated due to lack of evidence. Complaint IN00154236 - Unsubstantiated due to lack of evidence. Survey date: August 14 and 15, 2014 Facility number: 000101 Provider number: 155193 AIM number: 10029190 Survey team: Susan Worsham, RN, TC Census bed type: SNF/NF: 150 Total: 150 Census payor type: Medicare: 48 Medicaid: 93 Other: 9 Total: 150 Sample: 05 Kindred Transitional Care and Rehab -Greenwood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1 in regards to the Investigation of Complaints IN00153914 and IN0000154236. Quality Review 08/18/14 by Lisa McColly	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	**377 WESTRIDGE BLVD GREENWOOD, IN 46142**

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